John Elias Baldacci
Governor

John R. Nicholas
Commissioner

Maine Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011
Bureau of Medical Services

August 24, 2004

TO: Interested Parties

FROM: Christine Zukas-Lessard, Acting Director, Bureau of Medical Services

SUBJECT: Proposed Rules: 10-144 Chapter 101, MaineCare Benefits Manual (MBM), Chapter II, Section 4, Ambulatory Surgical Center Services

This proposed rule change caps reimbursement at 2002 Medicare rates.

Should special accommodations at the scheduled hearing or a copy of the proposed rule be needed please call (207) 287-9368 or TTY (207) 287-1828 (Deaf/Hard of Hearing) or TTY 1-800-423-4331 (Deaf/Hard of Hearing).

Rules and related rulemaking documents may be reviewed at and printed from the Bureau of Medical Services website at http://www.maine.gov/bms/MaineCareBenefitManualRules.htm or, for a fee, interested parties may request a paper copy of rules by contacting (207) 287-9368 or TTY: (207) 287-1828 or 1-800-423-4331.

Bureau of Medical Services
442 Civic Center Drive
Augusta, Maine 04333-0011

(207) 287-9368
Fax: (207) 287-9369
TTY: (207) 287-1828

Notice of Agency Rule-Making - Proposal

Agency: Department of Health and Human Services, Bureau of Medical Services

Chapter Number And Title 10-144 Chapter 101, MaineCare Benefits Manual (MBM), Chapter II, Section 4, Ambulatory Surgical Center Services.

Proposed rule number: (assigned by secretary of state)

Concise Summary: This proposed rule caps reimbursement at 2002 Medicare rates.

See http://www.maine.gov/bms/MaineCareBenefitManualRules.htm **for rules and related rulemaking documents**.

This rule will ☐ will not ☒ have a fiscal impact on municipalities

Statutory Authority: 22 M.R.S.A., § 42, § 3173

Public Hearing: Date: September 21, 2004, 2 PM

Location: Conference Room

Department of Health and Human Services
442 Civic Center Drive
Augusta, ME 04333-0011

Deadline for Comments: October 4, 2004

Agency Contact Person: Greg Nadeau

Agency : Bureau of Medical Services
Division of Policy and Provider Services
442 Civic Center Drive
11 State House Station
Augusta, ME 04333-0011

Telephone: (207) 287-9367 FAX: (207) 287-9369

TTY: 1-800-423-4331 or (207) 287-1828 (Deaf/Hard of Hearing)

Please approve bottom portion of this form and assign appropriate MFASIS number

Approved for payment _____ **Date:** _____

Authorized Signature

FUND: 013 **AGENCY:** 10A **ORG:** 3010 **APP:** 012 **JOB:** **OBJT:** **AMOUNT:**

SECTION 4 **AMBULATORY SURGICAL CENTER SERVICES**
2/1/90

TABLE OF CONTENTS

SECTION 4 **AMBULATORY SURGICAL CENTER SERVICES**
2/1/90

4.01 DEFINITIONS

4.01-1 Ambulatory Surgical Center (ASC) means a freestanding facility that operates exclusively for the purpose of providing surgical services to persons not requiring hospitalization. The ASC must be certified by Medicare and comply with applicable licensure requirements, if any, in the State or Province in which it operates.

Ambulatory Surgical Centers reimbursed as part of an acute care hospital are excluded as providers under this Section of the MaineCare Benefits Manual.

4.01-2 Facility Services means items and services furnished by an ASC in connection with a covered surgical procedure.

4.02 MEMBER ELIGIBILITY

Individuals must meet the financial eligibility criteria set forth in the MaineCare Eligibility Manual. Some members may have restrictions on the type and amount of services they are eligible to receive.

It is the responsibility of the provider to verify a member's eligibility for MaineCare prior to providing services on each occasion that services are provided. See Chapter I for more information on verifying eligibility.

4.03 DURATION OF CARE

Each MaineCare member is eligible for as many covered services as are medically necessary. The Department reserves the right to request additional information to determine medical necessity.

4.04 COVERED SERVICES

Covered services include all items and services furnished by an ASC in connection with a covered surgical procedure. Unless otherwise stated below, only surgical procedures currently on the Medicare-approved list of ASC covered procedures, which are based on the American Medical Association's CPT codes, are covered services. The following items and services are covered services and are included in the all-inclusive rates for reimbursement in this Section of the MaineCare Benefits Manual:

A. The following are part of the all-inclusive rate:

1. Nursing, technical personnel and other related services

4.04 **COVERED SERVICES** (cont.)

These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the ASC. In addition to the licensed nursing staff, this category includes technical personnel, and other support staff involved in patient care.

2. Use of surgical center facilities

3. Drugs, biologicals, surgical dressings, supplies, splints, appliances, casts, equipment

This category includes all drugs, medical supplies and equipment commonly furnished by the ASC, including oxygen in connection with surgical procedures. Drugs and biologicals are limited to those that cannot be self-administered.

4. Diagnostic or therapeutic items and services

These are items and services furnished by the ASC staff in connection with covered surgical procedures.

Diagnostic tests performed just before surgery, primarily urinalysis and blood hemoglobin, or hematocrit, are included in the facility fee. The laboratory may perform diagnostic tests that may be required prior to surgery. Generally, these tests will have been done prior to scheduling surgery.

5. Administrative, record-keeping, and housekeeping items

6. Blood, blood plasma, platelets

Covered procedures are limited to those not expected to result in extensive loss of blood, but in some cases, blood and blood products may be required. When there is a need for blood and blood products, they are considered facility services and no separate charge is permitted.

7. Materials for anesthesia

B. Prosthetic devices

Prostheses such as joint and breast implants, artificial eyes and limbs, etc. may be billed in addition to the facility fee, using procedure codes listed in the most current version of Medicare’s HCPCS, the Healthcare Common Procedure Coding System. Reimbursement will be made for the acquisition cost of the

4.04 **COVERED SERVICES** (cont.)

prosthetic device. Providers must maintain documentation of cost, including a copy of the original invoice, and make such documentation available to the Department upon request.

When an Ambulatory Surgical Center bills for services covered under this Section of the MaineCare Benefits Manual for a given operative procedure, the physician(s) involved in performing the operative procedure is to bill for his or her professional services only under Chapter II, Section 90, and not for related ancillary services such as anesthesia supplies, which are covered services under this Section.

4.05 **NON-COVERED SERVICES**

Facility services do not include physician services (Section 90); laboratory (Section 55), x-ray or diagnostic procedures (other than those directly related to the performance of the surgical procedure) (Section 101); ambulance services (Section 5); leg, arm and back braces; or durable medical equipment for use in the member's home (Section 60).

4.06 **POLICIES AND PROCEDURES**

4.06-1 Professional Staff

A physician is a doctor of medicine or osteopathy who possesses a current license to practice medicine or osteopathy in the State or Province in which the services are provided.

4.06-2 Member Records

There shall be a specific record for each member that shall include, but not necessarily be limited to:

A. The member's name, address, and birthdate;

B. The member's social and medical history, as appropriate;

C. Operative reports or procedure/treatment descriptions, as appropriate;

D. A description of any tests ordered and performed and their results;

E. A description of treatment or follow-up care and dates scheduled for revisits;

F. Any medications and/or supplies dispensed or prescribed;

4.06-2 Member Records (cont.)

G. Any recommendations for and referral to other sources of care;

H. The dates on which all services were provided; and

I. Written progress notes, which shall identify the services provided, pathology specimens obtained, and where sent, as applicable.

4.06-3 Surveillance and Utilization Review

See MaineCare Benefits Manual (MBM), Chapter I for Surveillance and Utilization Review procedures.

4.07 REIMBURSEMENT

Reimbursement for covered services shall be made as described below.~~on the basis of established procedure rates and shall encompass all facility services.~~ The reimbursement rate is an all inclusive rate. Providers cannot bill for facility services separately.

~~Reimbursement rates will be updated upon notification from the United States Government Centers for Medicare and Medicaid Services (CMS), formerly, Health Care Financing Administration, of changes in Medicare reimbursement rates for ambulatory surgical centers.~~

Reimbursement shall be the lower of:

A. the lowest amount allowed by the Maine Medicare Part B carrier for federal fiscal year 2002; or

B. the provider's usual and customary facility charge.

In accordance with Chapter I of the MaineCare Benefits Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment prior to billing the MaineCare Program.

4.07-1 Reimbursement for Multiple Procedures

When multiple ~~two or more~~ procedures are performed in the same operative session, MaineCare will only pay for ~~only~~ one procedure ~~will be paid for at the full standard rate for the procedure~~ classified in the highest payment group. ~~For multiple procedures performed in the same operative session, p~~Providers are to bill only the surgical procedure code (with modifier "F") in the highest payment group.

For purposes of this Section, an operative session is an ambulatory surgical visit in which one or more of the covered surgical procedures is performed.

For purposes of this Section, highest payment group is one of the nine payment groupings in Appendix A with the highest rate of reimbursement.

4.08 **BILLING INSTRUCTIONS**

~~Billing must be accomplished~~ Providers must bill in accordance with the Department's billing instructions.

Appendix A

ASC Payment Group	ASC Payment Amount
1	$333
2	$446
3	$510
4	$630
5	$717
6	$826
7	$995
8	$973
9	$1,339